PREVAILED	Roll Call No. _____
FAILED	Ayes _____
WITHDRAWN	Noes _____
RULED OUT OF ORDER	

HOUSE MOTION ____

MR. SPEAKER:

I move that House Bill 1347 be recommitted to a Committee of One, its author, with specific instructions to amend as follows:

Delete everything after the enacting clause and insert:

SECTION 1. IC 12-7-2-110 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 110. "Hospital" means the following:

(1) For purposes of IC 12-15-11.5, the meaning set forth in IC 12-15-11.5-1.

~~(1)~~ **(2)** For purposes of IC 12-15-18, the meaning set forth in IC 12-15-18-2.

~~(2)~~ **(3)** For purposes of IC 12-16, except IC 12-16-1, the term refers to a hospital licensed under IC 16-21.

SECTION 2. IC 12-15-11.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 11.5. Lake County Disproportionate Share Hospitals

Sec. 1. As used in this chapter, "hospital" refers to an acute care hospital provider that is:

(1) licensed under IC 16-21;

(2) qualifies as a disproportionate share hospital under IC 12-15-16; and

(3) is the sole disproportionate share hospital in a city located in a county having a population of more than four hundred thousand (400,000) but less than seven hundred thousand (700,000).

Sec. 2. (a) The office or the office's managed care contractor shall regard a hospital as a contracted provider in the office's managed care services program, which provides a capitated prepayment managed care system, for the provision of medical services to each individual who:

(1) is eligible to receive services under IC 12-15 and has enrolled in the office's managed care services program;

(2) resides in the same city in which the hospital is located; and

(3) has selected a primary care provider who:

(A) is a contracted provider with the office's managed care contractor; and

(B) has medical staff privileges at the hospital.

(b) This section expires June 30, 2001.

Sec. 3. (a) The office or the office's managed care contractor may not provide incentives or mandates to the primary medical provider to direct patients described in section 2 of this chapter to contracted hospitals other than a hospital in a city where the patient resides.

(b) This section expires June 30, 2001.

Sec. 4. (a) A hospital that:

(1) does not have a contract in effect with the office's managed care contractor; but

(2) previously contracted with the office's managed care contractor for the provision of services under the office's managed care program;

shall be reimbursed for services provided to patients described in section 2 of this chapter at rates equivalent to the rates negotiated under the hospital's previous contract with the office's managed care contractor, as adjusted for inflation by the inflation adjustment factor described in subsection (b). However, the adjusted rates may not exceed the established Medicaid rates paid to Medicaid providers who are not contracted providers in the office's managed health care services program.

(b) For each state fiscal year beginning after the effective date of the previous contract described in subsection (a)(2), an inflation adjustment factor shall be applied under subsection (a) that is equal to the percentage increase in the medical care component of the Consumer Price Index for all Urban Consumers, as published by the United States Bureau of Labor Statistics, for the twelve (12) month period ending in March preceding the beginning of the state fiscal year.

(c) This section expires June 30, 2001.

Sec. 5. (a) A hospital may enter into a contact with the office or the office's managed care contractor for reimbursement rates other than the reimbursement rates described in section 4 of this chapter.

(b) This section expires June 30, 2001.

Sec. 6. (a) A contract entered into by a hospital with the office's managed care contractor for the provision of services under the office's managed care services program must include a dispute resolution procedure for all denied claims submitted under the office's managed care services program and disputed by a hospital. The dispute resolution procedure must include the following:

(1) Submission of disputed claims to an independent arbitrator selected under subsection (b).

(2) Prompt submission of disputed claims from the office's managed care contractor to the arbitrator of any claims that remain in dispute sixty (60) calendar days after the hospital provides written notice to the office's managed care contractor that the hospital disputes the claims denial.

(3) Resolution of disputes by the arbitrator not later than sixty (60) calendar days after submission of denied claims to the arbitrator, unless the parties mutually agree otherwise.

(4) Determinations of the arbitrator to be final and binding, and not subject to any appeal or review procedure.

(5) Judgment upon the award rendered by the arbitrator may be entered and enforced in and is subject to the jurisdiction of a court with jurisdiction in Indiana.

(6) The cost of the arbitrator shall be shared equally by the parties.

(b) The parties to a contract described in subsection (a) shall mutually agree on an independent arbitrator, or, if the parties are unable to reach agreement on an independent arbitrator, the following procedure shall be followed:

(1) Each party shall select an independent individual, and the independent individuals shall select a panel of three (3) independent arbitrators.

(2) The parties will each strike one (1) arbitrator from the panel selected under subdivision (1), and the remaining arbitrator serves as the arbitrator of the disputed claims under subsection (a).

(3) The procedures for selecting an arbitrator under this section must be completed not later than fourteen (14) calendar days after the hospital provides written notice of at least one (1) disputed claims.

Sec. 7. The arbitration process described in section 6 of this chapter shall also be followed for resolution of claim disputes between a hospital and the office's managed care contractor, if the hospital is not a contracted provider in the office's managed health care services program.

SECTION 3. [EFFECTIVE UPON PASSAGE] **A hospital (as defined in IC 12-15-11.5-1, as added by this act) and the managed care contractor of the office (as defined in IC 12-7-2-134) shall use**

the arbitration procedure in IC 12-15-11.5-6, as added by this act, for the resolution of all disputed claim denials accrued as of the effective date of IC 12-15-11.5, as added by this act.

SECTION 4. **An emergency is declared for this act.**

(Reference is to HB 1347 as printed January 20, 2000.)

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Representative Brown C

Adopted	Rejected

COMMITTEE REPORT

MR. SPEAKER:

Your Committee of One, to which was referred House Bill 1347, begs leave to report that said bill has been amended as directed.

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Representative Brown C